

1 On what day and at what approximate time did the infant arrive at the hospital?

000 / / at :
 Month Day Year Military time

G. HOSPITAL INFORMATION

Infant's last name
 First name

2 Name of hospital:

000

3 Name of physician responsible for treatment at hospital:

000 First name 000 Last name

4 What did the infant look like upon arrival at the hospital? (check all that apply)

No Yes Specify

a) Coloring around the face, nose, and mouth	000 <input type="checkbox"/>	000 <input type="checkbox"/>	→ 000 <input type="text"/>
b) Secretions coming from nose or mouth	000 <input type="checkbox"/>	000 <input type="checkbox"/>	→ 000 <input type="text"/>
c) Skin discoloration (such as livor mortis, specify)	000 <input type="checkbox"/>	000 <input type="checkbox"/>	→ 000 <input type="text"/>
d) Pale areas around nose or mouth	000 <input type="checkbox"/>	000 <input type="checkbox"/>	→ 000 <input type="text"/>
e) Retinal hemorrhages	000 <input type="checkbox"/>	000 <input type="checkbox"/>	→ 000 <input type="text"/>
f) Cutaneous petechiae	000 <input type="checkbox"/>	000 <input type="checkbox"/>	→ 000 <input type="text"/>
g) Bruising or other injury	000 <input type="checkbox"/>	000 <input type="checkbox"/>	→ 000 <input type="text"/>
h) Suspicion of inflicted trauma	000 <input type="checkbox"/>	000 <input type="checkbox"/>	→ 000 <input type="text"/>
i) Other	000 <input type="checkbox"/>	000 <input type="checkbox"/>	→ 000 <input type="text"/>
j) Unknown	000 <input type="checkbox"/>	000 <input type="checkbox"/>	→ 000 <input type="text"/>

e.g., scratch on nose

5 How did the infant feel upon arrival at the hospital?

000 ☐ Sweaty 000 ☐ Warm to touch 000 ☐ Cool to touch 000 ☐ Rigid, stiff 000 ☐ Limp, flexible
 000 ☐ Unknown 000 ☐ Other → Specify

6 List all treatments administered to the infant at the hospital:

Name	Approx. time Military Time	Outcome
Treatment 1.....	000 <input type="text"/> : <input type="text"/> <input type="text"/>	000 <input type="text"/>
Treatment 2.....	000 <input type="text"/> : <input type="text"/> <input type="text"/>	000 <input type="text"/>
Treatment 3.....	000 <input type="text"/> : <input type="text"/> <input type="text"/>	000 <input type="text"/>
Treatment 4.....	000 <input type="text"/> : <input type="text"/> <input type="text"/>	000 <input type="text"/>
Treatment 5.....	000 <input type="text"/> : <input type="text"/> <input type="text"/>	000 <input type="text"/>

7 Describe the caregiver's or parents' reaction to the infant's death:

000

8 Were there any additional comments or observations made by hospital staff?

000 ☐ No
 000 ☐ Yes (Specify below)
 000